FOR OHF USE

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2003
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2003)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0042119

Facility Name: South Shore Nsg & Rehab Ctr

Address: 2649 E. 75Th Street (Number) Chicago (City) 60649 (Zip Code)

County: Cook

Telephone Number: (773) 356-9300 **Fax #** (773) 356-9384

IDPA ID Number: 364209295001

Date of Initial License for Current Owners: 05/28/98

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code			Corporation		Other
			"Sub-S" Corp.		
		X	Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: Steve Lavenda **Telephone Number:** (847) 236 - 1111

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/03 to 12/31/03 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider
(Signed) _____ (Date)
(Type or Print Name) _____
(Title) _____

Paid Preparer
(Signed) _____ (Date)
(Print Name and Title) Edward N. Slack, C.P.A.
(Firm Name & Address) Frost, Ruttenberg & Rothblatt, P.C.
111 Pfingsten Road, Suite 300 Deerfield, IL 60015
(Telephone) (847) 236-1111 Fax # (847) 236-1155

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number South Shore Nsg & Rehab Ctr # 0042119 Report Period Beginning: 01/01/03 Ending: 12/31/03

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	240	Skilled (SNF)	240	87,600	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	240	TOTALS	240	87,600	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	64,091	3,209	10,718	78,018	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	64,091	3,209	10,718	78,018	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 89.06%

D. How many bed-hold days during this year were paid by Public Aid?
1,385 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
N/A

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 05/28/98

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 05/28/98 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 30 and days of care provided 10,636

Medicare Intermediary AdminaStar Federal

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/31/03 Fiscal Year: 12/31/03

* All facilities other than governmental must report on the accrual basis.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number South Shore Nsg & Rehab Ctr # 0042119 Report Period Beginning: 01/01/03 Ending: 12/31/03

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger Salary/Wage 1	Supplies 2	Other 3	Total 4	Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY 9	10	
	A. General Services											
1	Dietary	308,363	38,065	20,485	366,913		366,913	(9,658)	357,255			1
2	Food Purchase		296,188		296,188	(7,950)	288,238	2,302	290,540			2
3	Housekeeping	237,436	57,553		294,989		294,989	(5,577)	289,412			3
4	Laundry	109,209	29,996		139,205		139,205	(573)	138,632			4
5	Heat and Other Utilities			280,283	280,283		280,283	2,044	282,327			5
6	Maintenance	45,414		252,358	297,772		297,772	4,867	302,639			6
7	Other (specify):*							3,342	3,342			7
8	**TOTAL General Services**	700,422	421,802	553,126	1,675,350	(7,950)	1,667,400	(3,253)	1,664,147			8
	B. Health Care and Programs											
9	Medical Director			9,000	9,000		9,000		9,000			9
10	Nursing and Medical Records	2,665,991	64,186	29,938	2,760,115		2,760,115	3,710	2,763,825			10
10a	Therapy	97,690	8,472	3,231	109,393		109,393	692	110,085			10a
11	Activities	153,908	4,975	1,781	160,664		160,664	37	160,701			11
12	Social Services	133,343		16,142	149,485		149,485	943	150,428			12
13	Nurse Aide Training											13
14	Program Transportation											14
15	Other (specify):*							5,277	5,277			15
16	**TOTAL Health Care and Programs**	3,050,932	77,633	60,092	3,188,657		3,188,657	10,659	3,199,316			16
	C. General Administration											
17	Administrative	88,016		216,000	304,016		304,016	(8,971)	295,045			17
18	Directors Fees											18
19	Professional Services			404,202	404,202		404,202	(347,141)	57,061			19
20	Dues, Fees, Subscriptions & Promotions			68,356	68,356		68,356	(28,446)	39,910			20
21	Clerical & General Office Expenses	76,583	18,476	395,504	490,563		490,563	(148,416)	342,147			21
22	Employee Benefits & Payroll Taxes			692,796	692,796	7,950	700,746	(49,863)	650,883			22
23	Inservice Training & Education			52	52		52		52			23
24	Travel and Seminar			477	477		477	1,341	1,818			24
25	Other Admin. Staff Transportation			226	226		226		226			25
26	Insurance-Prop.Liab.Malpractice			232,645	232,645		232,645	1,690	234,335			26
27	Other (specify):*							23,509	23,509			27
28	**TOTAL General Administration**	164,599	18,476	2,010,258	2,193,333	7,950	2,201,283	(556,297)	1,644,986			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	3,915,953	517,911	2,623,476	7,057,340		7,057,340	(548,892)	6,508,448			29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.

SEE ACCOUNTANTS' COMPILATION REPORT

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number South Shore Nsg & Rehab Ctr #0042119 Report Period Beginning: 01/01/03 Ending: 12/31/03

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			51,788	51,788		51,788	425,808	477,596			30
31	Amortization of Pre-Op. & Org.			703	703		703		703			31
32	Interest							816,375	816,375			32
33	Real Estate Taxes			341,807	341,807		341,807	3,036	344,843			33
34	Rent-Facility & Grounds			1,357,800	1,357,800		1,357,800	(1,352,775)	5,025			34
35	Rent-Equipment & Vehicles			10,677	10,677		10,677	2,118	12,795			35
36	Other (specify):*							15,373	15,373			36
37	**TOTAL Ownership**			1,762,775	1,762,775		1,762,775	(90,065)	1,672,710			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers	19,313	426,451	620,808	1,066,572		1,066,572	(12,812)	1,053,760			39
40	Barber and Beauty Shops			15	15		15		15			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			131,400	131,400		131,400		131,400			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**	19,313	426,451	752,223	1,197,987		1,197,987	(12,812)	1,185,175			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	3,935,266	944,362	5,138,474	10,018,102		10,018,102	(651,768)	9,366,334			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number South Shore Nsg & Rehab Ctr # 0042119 Report Period Beginning: 01/01/03 Ending: 12/31/03

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(21,478)	30		9
10	Interest and Other Investment Income	(289,428)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(120)	02		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(300,000)	21		24
25	Fund Raising, Advertising and Promotional	(4,922)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(95,118)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (711,066)		$	30

OHF USE ONLY								
48		49		50		51		52

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	59,297		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 59,297		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (651,768)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

SEE ACCOUNTANTS' COMPILATION REPORT

STATE OF ILLINOIS

South Shore Nsg & Rehab Ctr

ID# 0042119

Report Period Beginning: 01/01/03

Ending: 12/31/03

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Jury Duty	$ (86)	21	1
2	Patient Clothing	(171)	10	2
3	Collection Expense	(1,822)	21	3
4	Bank Charges	(8,174)	21	4
5	Mis. Non-Deductibles	(72)	21	5
6	Theft Loss	(515)	21	6
7	Theft Loss	(163)	21	7
8	ICLTC Cope Payments	(3,052)	20	8
9	LLC Fee	(150)	20	9
10	Daiwa Fee	(3,391)	19	10
11	Admin. Expense - Bldg. Co.	(400)	21	11
12	Bank Charges - Bldg. Co.	(60)	21	12
13	Trust Fees - Bldg. Co.	(150)	21	13
14	Management Fees - Ron Abrams	(12,000)	17	14
15	Management Fees - Alan Abrams	(12,000)	17	15
16	Prior Period City of Chicago Tax	(2,761)	21	16
17	Prior Period Office Expense	(2,366)	21	17
18	Prior Period Lab	(3,233)	39	18
19	Prior Period Auto Lease	(329)	35	19
20	Prior Period Expense	(3,281)	21	20
21	Prior Period Insurance	(38,107)	22	21
22	Prior Period Uniform Expense	(677)	22	22
23	Capitalized Repairs & Maintenance	(2,158)	06	23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
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98				98
99				99
100				100
101	**Total**	(95,118)		101

STATE OF ILLINOIS

Summary A

Facility Name & ID Number South Shore Nsg & Rehab Ctr # 0042119 Report Period Beginning: 01/01/03 Ending: 12/31/03

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary			68		(4,299)	(3,323)		(2,104)				(9,658)	1
2	Food Purchase	(120)		(120)			2,542						2,302	2
3	Housekeeping					1,281			(6,858)				(5,577)	3
4	Laundry								(573)				(573)	4
5	Heat and Other Utilities			2,044									2,044	5
6	Maintenance	(2,158)		2,133	256	4,690	7		(61)				4,867	6
7	Other (specify):*				1,866	1,294	182						3,342	7
8	**TOTAL General Services**	(2,278)		4,125	2,122	2,966	(592)		(9,596)				(3,253)	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records	(171)		270	(6,156)	14,810			(5,043)				3,710	10
10a	Therapy					692							692	10a
11	Activities			37									37	11
12	Social Services				737	206							943	12
13	Nurse Aide Training													13
14	Program Transportation													14
15	Other (specify):*				3,366	1,911							5,277	15
16	**TOTAL Health Care and Programs**	(171)		307	(2,053)	17,619			(5,043)				10,659	16
	C. General Administration													
17	Administrative	(24,000)				14,899	130						(8,971)	17
18	Directors Fees													18
19	Professional Services	(3,391)		(343,793)			43						(347,141)	19
20	Fees, Subscriptions & Promotions	(8,124)		(20,334)			12						(28,446)	20
21	Clerical & General Office Expenses	(319,850)	610	22,729		147,817	278						(148,416)	21
22	Employee Benefits & Payroll Taxes	(38,784)			(10,150)			(379)	(550)				(49,863)	22
23	Inservice Training & Education													23
24	Travel and Seminar			983			358						1,341	24
25	Other Admin. Staff Transportation													25
26	Insurance-Prop.Liab.Malpractice			1,690									1,690	26
27	Other (specify):*				3,404	20,105							23,509	27
28	**TOTAL General Administration**	(394,149)	610	(338,725)	(6,746)	182,821	821	(379)	(550)				(556,297)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(396,598)	610	(334,293)	(6,677)	203,406	229	(379)	(15,190)				(548,892)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number South Shore Nsg & Rehab Ctr # 0042119 **Report Period Beginning:** 01/01/03 **Ending:** 12/31/03

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	(21,478)	436,403	10,883									425,808	30
31	Amortization of Pre-Op. & Org.													31
32	Interest	(289,428)	1,084,381	21,419			3						816,375	32
33	Real Estate Taxes			3,036									3,036	33
34	Rent-Facility & Grounds		(1,357,800)	5,025									(1,352,775)	34
35	Rent-Equipment & Vehicles	(329)		2,377			70						2,118	35
36	Other (specify):*		15,373										15,373	36
37	**TOTAL Ownership**	(311,235)	178,357	42,740			73						(90,065)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation													38
39	Ancillary Service Centers	(3,233)					(2,392)		(7,187)				(12,812)	39
40	Barber and Beauty Shops													40
41	Coffee and Gift Shops													41
42	Provider Participation Fee													42
43	Other (specify):*													43
44	**TOTAL Special Cost Centers**	(3,233)					(2,392)		(7,187)				(12,812)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(711,066)	178,967	(291,553)	(6,677)	203,406	(2,090)	(379)	(22,377)				(651,768)	45

Facility Name & ID Number South Shore Nsg & Rehab Ctr # 0042119 Report Period Beginning: 01/01/03 Ending: 12/31/03

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
See Attached Schedule		See Attached Schedule		See Attached Schedule		
				South Shore Properties, LLC		

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

	1 Schedule V	2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	34	Rental Income	$ 1,357,800	South Shore Properties, LLC		$	$ (1,357,800)	1
2	V	21	Admin Expense		South Shore Properties, LLC		400	400	2
3	V	21	Bank Charges		South Shore Properties, LLC		60	60	3
4	V	21	Trust Fees		South Shore Properties, LLC		150	150	4
5	V	30	Depreciation		South Shore Properties, LLC		436,403	436,403	5
6	V	36	Amortization Expense		South Shore Properties, LLC		15,373	15,373	6
7	V	32	Interest Expense		South Shore Properties, LLC		1,084,381	1,084,381	7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$ 1,357,800			$ 1,536,767	$ * 178,967	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number South Shore Nsg & Rehab Ctr # 0042119 Report Period Beginning: 01/01/03 Ending: 12/31/03

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

	1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V		01	Dietary	$	Care Centers, Inc.	100.00%	$ 68	$ 68	15
16	V		05	Utilities		Care Centers, Inc.	100.00%	2,044	2,044	16
17	V		06	Maintenance		Care Centers, Inc.	100.00%	2,133	2,133	17
18	V		10	Nursing	40	Care Centers, Inc.	100.00%	310	270	18
19	V		11	Activities		Care Centers, Inc.	100.00%	37	37	19
20	V		19	Professional Fees	357,456	Care Centers, Inc.	100.00%	13,663	(343,793)	20
21	V		20	Dues and Subscriptions	21,900	Care Centers, Inc.	100.00%	1,566	(20,334)	21
22	V		21	Office & Clerical		Care Centers, Inc.	100.00%	22,729	22,729	22
23	V		24	Travel and Seminar		Care Centers, Inc.	100.00%	983	983	23
24	V		26	Insurance		Care Centers, Inc.	100.00%	1,690	1,690	24
25	V		30	Depreciation		Care Centers, Inc.	100.00%	10,883	10,883	25
26	V		32	Interest		Care Centers, Inc.	100.00%	21,419	21,419	26
27	V		33	Real Estate Taxes		Care Centers, Inc.	100.00%	3,036	3,036	27
28	V		34	Rent - Building		Care Centers, Inc.	100.00%	5,025	5,025	28
29	V		35	Rent - Equipment and Auto		Care Centers, Inc.	100.00%	2,377	2,377	29
30	V		25	Bus Reimbursement		Care Centers, Inc.	100.00%			30
31	V		02	Food	120	Care Centers, Inc.	100.00%		(120)	31
32	V									32
33	V									33
34	V									34
35	V									35
36	V									36
37	V									37
38	V									38
39	Total				$ 379,516			$ 87,963	$ * (291,553)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number South Shore Nsg & Rehab Ctr # 0042119 Report Period Beginning: 01/01/03 Ending: 12/31/03

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	06	Maintenance Salary	$ 14,478	Care Centers, Inc.	100.00%	$ 14,734	$ 256	15
16	V	07	Emp. Ben. - Gen. Serv.		Care Centers, Inc.	100.00%	1,866	1,866	16
17	V	10	Nursing Salary	15,881	Care Centers, Inc.	100.00%	9,725	(6,156)	17
18	V	10a	Rehab Salary	125	Care Centers, Inc.	100.00%	125		18
19	V	11	Activity Salary	629	Care Centers, Inc.	100.00%	629		19
20	V	12	Social Service Salary	15,565	Care Centers, Inc.	100.00%	16,302	737	20
21	V	15	Emp. Ben. - Healthcare		Care Centers, Inc.	100.00%	3,366	3,366	21
22	V	17	Administration Salary		Care Centers, Inc.	100.00%			22
23	V	21	Office Salary	26,438	Care Centers, Inc.	100.00%	26,438		23
24	V	27	Emp. Ben. - Gen. Admin.		Care Centers, Inc.	100.00%	3,404	3,404	24
25	V	22	Employee Benefits	10,150	Care Centers, Inc.	100.00%		(10,150)	25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 83,266			$ 76,589	$ * (6,677)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number South Shore Nsg & Rehab Ctr # 0042119 Report Period Beginning: 01/01/03 Ending: 12/31/03

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	01	Dietary Salary	$ 8,760	Care Centers, Inc.	100.00%	$ 4,461	$ (4,299)	15
16	V	03	Housekeeping Salary		Care Centers, Inc.	100.00%	1,281	1,281	16
17	V	06	Maintenance Salary		Care Centers, Inc.	100.00%	4,690	4,690	17
18	V	07	Emp. Ben. - Gen. Serv.		Care Centers, Inc.	100.00%	1,294	1,294	18
19	V	10	Nursing Salary		Care Centers, Inc.	100.00%	14,810	14,810	19
20	V	10a	Rehab Salary		Care Centers, Inc.	100.00%	692	692	20
21	V	12	Social Services Salary		Care Centers, Inc.	100.00%	206	206	21
22	V	15	Emp. Ben. - Healthcare		Care Centers, Inc.	100.00%	1,911	1,911	22
23	V	17	Administration Salary		Care Centers, Inc.	100.00%	14,899	14,899	23
24	V	21	Office Salary		Care Centers, Inc.	100.00%	147,817	147,817	24
25	V	27	Emp. Ben. - Gen. Admin.		Care Centers, Inc.	100.00%	20,105	20,105	25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 8,760			$ 212,166	$ * 203,406	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number South Shore Nsg & Rehab Ctr # 0042119 Report Period Beginning: 01/01/03 Ending: 12/31/03

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	01	Dietary	$ 5,447	Care Centers, Inc. - Health Systems Division	100.00%	$ 723	$ (4,724)	15
16	V	02	Food		Care Centers, Inc. - Health Systems Division	100.00%	2,542	2,542	16
17	V	06	Maintenance		Care Centers, Inc. - Health Systems Division	100.00%	7	7	17
18	V	17	Administration		Care Centers, Inc. - Health Systems Division	100.00%	130	130	18
19	V	19	Professional Fees		Care Centers, Inc. - Health Systems Division	100.00%	43	43	19
20	V	20	Dues & Subscriptions		Care Centers, Inc. - Health Systems Division	100.00%	12	12	20
21	V	21	Office & Clerical		Care Centers, Inc. - Health Systems Division	100.00%	278	278	21
22	V	24	Travel & Seminar		Care Centers, Inc. - Health Systems Division	100.00%	358	358	22
23	V	32	Interest Expense		Care Centers, Inc. - Health Systems Division	100.00%	3	3	23
24	V	35	Rent - Equipment & Auto		Care Centers, Inc. - Health Systems Division	100.00%	70	70	24
25	V	39	Ancillary Enteral Supplies	4,898	Care Centers, Inc. - Health Systems Division	100.00%	2,506	(2,392)	25
26	V	01	Dietary - Salary		Care Centers, Inc. - Health Systems Division	100.00%	1,401	1,401	26
27	V	07	Emp. Ben. - Gen. Serv.		Care Centers, Inc. - Health Systems Division	100.00%	182	182	27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 10,345			$ 8,255	$ * (2,090)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number South Shore Nsg & Rehab Ctr # 0042119 Report Period Beginning: 01/01/03 Ending: 12/31/03

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

	1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V		22	EMPLOYEE HEALTH INSURANCE	$	CCS EMPLOYEE BENEFIT GROUP	100.00%	$ 89,851	$ 89,851	15
16	V									16
17	V									17
18	V									18
19	V		22	EMPLOYEE HEALTH INSURANCE	90,230	CCS EMPLOYEE BENEFIT GROUP	100.00%		(90,230)	19
20	V									20
21	V									21
22	V									22
23	V									23
24	V									24
25	V									25
26	V									26
27	V									27
28	V									28
29	V									29
30	V									30
31	V									31
32	V									32
33	V									33
34	V									34
35	V									35
36	V									36
37	V									37
38	V									38
39	Total				$ 90,230			$ 89,851	$ * (379)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number South Shore Nsg & Rehab Ctr # 0042119 Report Period Beginning: 01/01/03 Ending: 12/31/03

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	01	DIETARY	$ 15,987	XCEL MEDICAL SUPPLY, LLC	100.00%	$ 13,882	$ (2,104)	15
16	V	02	FOOD		XCEL MEDICAL SUPPLY, LLC	100.00%			16
17	V	03	HOUSEKEEPING	52,104	XCEL MEDICAL SUPPLY, LLC	100.00%	45,245	(6,858)	17
18	V	04	LAUNDRY	4,353	XCEL MEDICAL SUPPLY, LLC	100.00%	3,780	(573)	18
19	V	06	REPAIRS & MAINTENANCE	461	XCEL MEDICAL SUPPLY, LLC	100.00%	401	(61)	19
20	V	10	NURSING	38,316	XCEL MEDICAL SUPPLY, LLC	100.00%	33,273	(5,043)	20
21	V	10A	THERAPY		XCEL MEDICAL SUPPLY, LLC	100.00%			21
22	V	12	SOCIAL SERVICE		XCEL MEDICAL SUPPLY, LLC	100.00%			22
23	V	21	CLERICAL & GENERAL OFFICE		XCEL MEDICAL SUPPLY, LLC	100.00%			23
24	V	22	EMPLOYEE BENEFITS	4,179	XCEL MEDICAL SUPPLY, LLC	100.00%	3,629	(550)	24
25	V	39	ANCILLARY	54,602	XCEL MEDICAL SUPPLY, LLC	100.00%	47,415	(7,187)	25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 170,001			$ 147,624	$ * (22,377)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number South Shore Nsg & Rehab Ctr # 0042119 Report Period Beginning: 01/01/03 Ending: 12/31/03

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

	1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V				$			$	$	15
16	V									16
17	V									17
18	V									18
19	V									19
20	V									20
21	V									21
22	V									22
23	V									23
24	V									24
25	V									25
26	V									26
27	V									27
28	V									28
29	V									29
30	V									30
31	V									31
32	V									32
33	V									33
34	V									34
35	V									35
36	V									36
37	V									37
38	V									38
39	Total				$			$	$ *	39

*** Total must agree with the amount recorded on line 34 of Schedule VI.**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number South Shore Nsg & Rehab Ctr # 0042119 Report Period Beginning: 01/01/03 Ending: 12/31/03

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

	1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V				$			$	$	15
16	V									16
17	V									17
18	V									18
19	V									19
20	V									20
21	V									21
22	V									22
23	V									23
24	V									24
25	V									25
26	V									26
27	V									27
28	V									28
29	V									29
30	V									30
31	V									31
32	V									32
33	V									33
34	V									34
35	V									35
36	V									36
37	V									37
38	V									38
39	Total				$			$	$ *	39

*** Total must agree with the amount recorded on line 34 of Schedule VI.**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number South Shore Nsg & Rehab Ctr # 0042119 Report Period Beginning: 01/01/03 Ending: 12/31/03

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

*** Total must agree with the amount recorded on line 34 of Schedule VI.**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number South Shore Nsg & Rehab Ctr # 0042119 Report Period Beginning: 01/01/03 Ending: 12/31/03

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
						Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**			
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Hours	Percent	Description	Amount	Schedule V. Line & Column Reference	
1	David Aronin	Owner	Administrative	0.83%	See Attached	2.00	4.00%	CCI Salary	$ 4,420	17-07	1
2	Sandy Bokor	Relative	Administrative	0.00%	See Attached	1.00	2.00%	Mgmt. Fee	12,000	17-03	2
3	Mark Steinberg	Relative	Administrative	0.00%	See Attached	2.50	4.95%	CCI Salary	2,068	17-07	3
4	Eric Rothner	Relative	Administrative	0.00%	See Attached	1.66	3.02%	Mgmt. Fee	180,000	17-03	4
5	Adam Vales	Owner	Clerical	1.88%	See Attached	0.46	1.15%	CCS VEBA Sal	360	22-07	5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$ 198,848		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number South Shore Nsg & Rehab Ctr # 0042119 Report Period Beginning: 01/01/03 Ending: 12/31/03

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [ ] NO [X]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number South Shore Nsg & Rehab Ctr # 0042119 Report Period Beginning: 01/01/03 Ending: 12/31/03

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: Care Centers, Inc.
Street Address: 2202 West Main Street
City / State / Zip Code: Evanston, Illinois 60202
Phone Number: (847) 905-3000
Fax Number: (847) 905-3030

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	01	Dietary	Patient Days	1,764,895	42	$ 1,527	$	78,018	$ 68	1
2	05	Utilities	Patient Days	1,764,895	42	46,229		78,018	2,044	2
3	06	Maintenance	Patient Days	1,764,895	42	48,251		78,018	2,133	3
4	10	Nursing	Patient Days	1,764,895	42	7,018		78,018	310	4
5	11	Activities	Patient Days	1,764,895	42	838		78,018	37	5
6	19	Professional Fees	Patient Days	1,764,895	42	309,074		78,018	13,663	6
7	20	Dues and Subscriptions	Patient Days	1,764,895	42	35,428		78,018	1,566	7
8	21	Office & Clerical	Patient Days	1,764,895	42	523,091		78,018	22,729	8
9	24	Travel and Seminar	Patient Days	1,764,895	42	22,233		78,018	983	9
10	26	Insurance	Patient Days	1,764,895	42	38,230		78,018	1,690	10
11	30	Depreciation	Patient Days	1,764,895	42	246,194		78,018	10,883	11
12	32	Interest	Patient Days	1,764,895	42	484,531		78,018	21,419	12
13	33	Real Estate Taxes	Patient Days	1,764,895	42	68,681		78,018	3,036	13
14	34	Rent - Building	Patient Days	1,764,895	42	113,677		78,018	5,025	14
15	35	Rent - Equipment & Auto	Patient Days	1,764,895	42	53,777		78,018	2,377	15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 1,998,780	$		$ 87,963	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number South Shore Nsg & Rehab Ctr # 0042119 Report Period Beginning: 01/01/03 Ending: 12/31/03

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: Care Centers, Inc.
Street Address: 2202 West Main Street
City / State / Zip Code: Evanston, Illinois 60202
Phone Number: (847) 905-3000
Fax Number: (847) 905-3030

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	06	Maintenance Salary	Direct Cost			213,393	213,393		14,734	1
2	07	Emp. Ben. - Gen. Serv.	Direct Cost			26,918			1,866	2
3	10	Nursing Salary	Direct Cost			976,718	976,718		9,725	3
4	10a	Rehab Salary	Direct Cost			103,898	103,898		125	4
5	11	Activity Salary	Direct Cost			10,902	10,902		629	5
6	12	Social Service Salary	Direct Cost			306,863	306,863		16,302	6
7	15	Emp. Ben. - Healthcare	Direct Cost			174,348			3,366	7
8	17	Administration Salary	Direct Cost			1,191,200	1,191,200			8
9	21	Office Salary	Direct Cost			698,886	698,886		26,438	9
10	27	Emp. Ben. - Gen. Admin.	Direct Cost			238,998			3,404	10
11	22	Employee Benefits								11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 3,942,124	$ 3,501,860		$ 76,589	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number South Shore Nsg & Rehab Ctr # 0042119 Report Period Beginning: 01/01/03 Ending: 12/31/03

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: Care Centers, Inc.
Street Address: 2202 West Main Street
City / State / Zip Code: Evanston, Illinois 60202
Phone Number: (847) 905-3000
Fax Number: (847) 905-3030

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	01	Dietary Salary	Patient Days	1,764,895	42	100,923	100,923	78,018	4,461	1
2	03	Housekeeping Salary	Patient Days	1,764,895	42	28,979	28,979	78,018	1,281	2
3	06	Maintenance Salary	Patient Days	1,764,895	42	106,088	106,088	78,018	4,690	3
4	07	Emp. Ben. - Gen. Serv.	Patient Days	1,764,895	42	29,264		78,018	1,294	4
5	10	Nursing Salary	Patient Days	1,764,895	42	335,028	335,028	78,018	14,810	5
6	10a	Rehab Salary	Patient Days	1,764,895	42	15,649	15,649	78,018	692	6
7	12	Social Services Salary	Patient Days	1,764,895	42	4,661	4,661	78,018	206	7
8	15	Emp. Ben. - Healthcare	Patient Days	1,764,895	42	43,235		78,018	1,911	8
9	17	Administration Salary	Patient Days	1,764,895	42	337,043	337,043	78,018	14,899	9
10	21	Office Salary	Patient Days	1,764,895	42	3,343,864	3,343,864	78,018	147,817	10
11	27	Emp. Ben. - Gen. Admin.	Patient Days	1,764,895	42	454,813		78,018	20,105	11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 4,799,547	$ 4,272,235		$ 212,166	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number South Shore Nsg & Rehab Ctr # 0042119 Report Period Beginning: 01/01/03 Ending: 12/31/03

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: Care Centers, Inc.
Street Address: 2202 West Main Street
City / State / Zip Code: Evanston, Illinois 60202
Phone Number: (847) 905-3000
Fax Number: (847) 905-3030

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	01	Dietary	Billable Income	2,073,579		138,556		10,817	723	1
2	02	Food	Billable Income	2,073,579		852,614		10,817	2,542	2
3	06	Maintenance	Billable Income	2,073,579		1,311		10,817	7	3
4	17	Administration	Billable Income	2,073,579		25,000		10,817	130	4
5	19	Professional Fees	Billable Income	2,073,579		8,170		10,817	43	5
6	20	Dues & Subscriptions	Billable Income	2,073,579		2,312		10,817	12	6
7	21	Office & Clerical	Billable Income	2,073,579		53,285		10,817	278	7
8	24	Travel & Seminar	Billable Income	2,073,579		68,680		10,817	358	8
9	32	Interest Expense	Billable Income	2,073,579		571		10,817	3	9
10	35	Rent - Equipment & Auto	Billable Income	2,073,579		13,336		10,817	70	10
11	39	Ancillary Enteral Supplies	Billable Income	2,073,579		114,955		10,817	2,506	11
12	01	Dietary - Salary	Billable Income	2,073,579		268,554	268,554	10,817	1,401	12
13	07	Emp. Ben. - Gen. Serv.	Billable Income	2,073,579		34,942		10,817	182	13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 1,582,287	$ 268,554		$ 8,255	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number South Shore Nsg & Rehab Ctr # 0042119 Report Period Beginning: 01/01/03 Ending: 12/31/03

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: CCS EMPLOYEE BENEFITS GROUP, INC.
Street Address: 4101 W. MAIN ST.
City / State / Zip Code: SKOKIE, IL 60076
Phone Number: (847)905-4000
Fax Number: (847)905-4040

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	22	EMPLOYEE HEALTH INSURA	DIRECT ALLOCATION			$	$		$ 89,851	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$ 89,851	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number South Shore Nsg & Rehab Ctr # 0042119 Report Period Beginning: 01/01/03 Ending: 12/31/03

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: XCEL MEDICAL SUPPLY, LLC
Street Address: 2201 MAIN STREET
City / State / Zip Code: EVANSTON, IL 60202
Phone Number: (847)328-7600
Fax Number: (847)328-7615

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	01	DIETARY	Direct Allocation			$	$		$ 13,882	1
2	02	FOOD	Direct Allocation							2
3	03	HOUSEKEEPING	Direct Allocation						45,245	3
4	04	LAUNDRY	Direct Allocation						3,780	4
5	06	REPAIRS & MAINTENANCE	Direct Allocation						401	5
6	10	NURSING	Direct Allocation						33,273	6
7	10A	THERAPY	Direct Allocation							7
8	12	SOCIAL SERVICE	Direct Allocation							8
9	21	CLERICAL & GENERAL OFFIC	Direct Allocation							9
10	22	EMPLOYEE BENEFITS	Direct Allocation						3,629	10
11	39	ANCILLARY	Direct Allocation						47,415	11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$ 147,624	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number South Shore Nsg & Rehab Ctr # 0042119 Report Period Beginning: 01/01/03 Ending: 12/31/03

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number South Shore Nsg & Rehab Ctr # 0042119 Report Period Beginning: 01/01/03 Ending: 12/31/03

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number South Shore Nsg & Rehab Ctr # 0042119 Report Period Beginning: 01/01/03 Ending: 12/31/03

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number South Shore Nsg & Rehab Ctr # 0042119 Report Period Beginning: 01/01/03 Ending: 12/31/03

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1	Corus Bank		X	Mortgage - Bldg. Co.			$	$ 9,419,641			$ 787,802	1
2	CIB Bank		X	Mortgage - Bldg. Co.				3,356,609			283,224	2
3												3
4												4
5	See Supplemental Schedule											5
	Working Capital											
6	Alloc. - Care Centers, Inc.		X								21,419	6
7												7
8	See Supplemental Schedule										3	8
9	TOTAL Facility Related						$	$ 12,776,250			$ 1,092,448	9
	B. Non-Facility Related*											
10												10
11	Interest Income		X								(289,428)	11
12												12
13	See Supplemental Schedule										13,355	13
14	TOTAL Non-Facility Related						$	$			$ (276,073)	14
15	TOTALS (line 9+line14)						$	$ 12,776,250			$ 816,375	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ 0 Line # N/A

*** Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)**

SEE ACCOUNTANTS' COMPILATION REPORT

**** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)**

Facility Name & ID Number South Shore Nsg & Rehab Ctr # 0042119 Report Period Beginning: 01/01/03 Ending: 12/31/03

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE - SUPPLEMENTAL SCHEDULE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1							$	$			$	1
2												2
3												3
4												4
5												5
6												6
7	TOTAL Long-Term											7
	Working Capital											
8	Alloc. Care Centers, Inc. -						$	$			$	8
9	Health Systems Division		X								3	9
10												10
11												11
12												12
13												13
14	TOTAL Working Capital										3	14
	B. Non-Facility Related*											
15	South Shore Nursing Home	X		Bldg. Co.			$	$			$ 13,355	15
16	Adjusted out with interest											16
17	income											17
18												18
19												19
20	TOTAL Non-Facility Related										13,355	20

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

SEE ACCOUNTANTS' COMPILATION REPORT

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Facility Name & ID Number South Shore Nsg & Rehab Ctr # 0042119 Report Period Beginning: 01/01/03 Ending: 12/31/03

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2002 report. *Important*, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.	$	343,109	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	$	337,139	2
3. Under or (over) accrual (line 2 minus line 1).	$	(5,970)	3
4. Real Estate Tax accrual used for 2003 report. (Detail and explain your calculation of this accrual on the lines below.)	$	350,813	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**	$		5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year. (Attach a copy of the real estate tax appeal board's decision.)**	$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	$	344,843	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	1998	108,397	8
	1999	266,137	9
	2000	324,625	10
	2001	332,159	11
	2002	334,103	12

2003 Real Estate Tax Accrual = 2002 Real Estate Tax $334,103 X 1.05 = approximately $350,813 .

Line 2 Includes $3,036 Allocation from Care Centers, Inc.

	FOR OHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2002	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

SEE ACCOUNTANTS' COMPILATION REPORT

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2002 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2002 real estate tax costs, as well as copies of your real estate tax bills for calendar 2002.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2002 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2003 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2002 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME South Shore Nsg & Rehab Ctr COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0042119

CONTACT PERSON REGARDING THIS REPORT : Steve Lavenda

TELEPHONE (847) 236-1111 FAX #: (847) 236-1155

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2002 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2002.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	21-30-121-008-0000	Long Term Care Property	$ 1,683.83	$ 1,683.83
2.	21-30-121-009-0000	Long Term Care Property	$ 1,985.60	$ 1,985.60
3.	21-30-200-001-0000	Long Term Care Property	$ 275,241.76	$ 275,241.76
4.	21-30-200-008-0000	Long Term Care Property	$ 51,564.24	$ 51,564.24
5.	21-30-200-002-0000	Long Term Care Property	$ 3,627.88	$ 3,627.88
6.	See Attached	Home Office Allocation	$ 68,681.49	$ 3,036.10
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 402,784.80	$ 337,139.41

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? X YES _____ NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the 2002 tax bills which were listed in Section A to this statement. Be sure to use the 2002 tax bill which is normally paid during 2003.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2000 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2000 real estate tax costs, as well as copies of your real estate tax bills for calendar 2000.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2000 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2001 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2002 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME South Shore Nsg & Rehab Ctr COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0042119

CONTACT PERSON REGARDING THIS REPORT : Steve Lavenda

TELEPHONE (847) 236-1111 FAX #: (847) 236-1155

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2000 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2000.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.			$	$
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$	$

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? _____ YES _____ NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the 2000 tax bills which were listed in Section A to this statement. Be sure to use the 2000 tax bill which is normally paid during 2001.

Facility Name & ID Number South Shore Nsg & Rehab Ctr # 0042119 Report Period Beginning: 01/01/03 Ending: 12/31/03

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 96,000 B. General Construction Type: Exterior Brick Frame Steel & Masonry Number of Stories 3

C. Does the Operating Entity? [ ] (a) Own the Facility [X] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [X] (a) Own the Equipment [X] (b) Rent equipment from a Related Organization. [X] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

None

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [X] YES [ ] NO
If so, please complete the following:

1. Total Amount Incurred: 115,306
2. Number of Years Over Which it is Being Amortized:
3. Current Period Amortization: 703
4. Dates Incurred: Various

Nature of Costs: Financing Fees, Closing Costs, Loan Fees
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Facility	101,000	1994	$ 352,000	1
2	Alloc. - CCI			22,474	2
3	TOTALS	101,000		$ 374,474	3

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number South Shore Nsg & Rehab Ctr # 0042119 Report Period Beginning: 01/01/03 Ending: 12/31/03

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Various			1998	22,697		20	1,135	1,135	6,025	9
10	Various			1999	22,789		20	1,140	1,140	4,877	10
11								-		-	11
12								-		-	12
13								-		-	13
14								-		-	14
15								-		-	15
16								-		-	16
17								-		-	17
18								-		-	18
19								-		-	19
20								-		-	20
21								-		-	21
22								-		-	22
23								-		-	23
24								-		-	24
25								-		-	25
26								-		-	26
27								-		-	27
28								-		-	28
29								-		-	29
30								-		-	30
31								-		-	31
32								-		-	32
33								-		-	33
34								-		-	34
35								-		-	35
36								-		-	36

*Total beds on this schedule must agree with page 2.

See Page 12A, Line 70 for total

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number South Shore Nsg & Rehab Ctr # 0042119 Report Period Beginning: 01/01/03 Ending: 12/31/03

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			$	$		$	$	$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
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56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67	Related Building Company (Pages 12-BLDG & 12A-BLDG)		11,725,819	260,958		335,240	74,282	1,832,913	67
68	Related Party Allocations (Pages 12-REP & 12A-REP)		85,009	2,842		2,842		3,026	68
69	Financial Statement Depreciation			43,126			(43,126)		69
70	TOTAL (lines 4 thru 69)		$ 11,856,314	$ 306,926		$ 340,357	$ 33,431	$ 1,846,841	70

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number South Shore Nsg & Rehab Ctr # 0042119 Report Period Beginning: 01/01/03 Ending: 12/31/03

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		$ 11,856,314	$ 306,926		$ 340,357	$ 33,431	$ 1,846,841	1
2	Boiler Renov	2000	967		20	48	48	193	2
3	Tv Wiring	2000	18,268		20	913	913	3,577	3
4	Cabling	2000	952		20	48	48	183	4
5	Plumbing Renov	2000	894		20	45	45	168	5
6	Water Heater	2000	9,417		20	471	471	1,766	6
7	Hvac	2000	4,562		20	228	228	817	7
8	Hvac	2000	5,908		20	295	295	1,083	8
9	Elevator Parts	2000	558		20	28	28	96	9
10	Hot Water Heater	2001	3,980		20	199	199	597	10
11	Fan Power Box	2001	589		20	29	29	86	11
12	Exit Sign	2001	2,336		20	117	117	322	12
13	Chiller Bundle	2001	2,020		20	101	101	269	13
14	Sprinkler System	2001	1,405		20	70	70	182	14
15	Cyllander Assy	2001	2,394		20	120	120	289	15
16	Bypass On Water Heat	2001	2,146		20	107	107	251	16
17	Boiler	2001	4,000		20	200	200	450	17
18	Tube Sections	2001	6,074		20	304	304	683	18
19	Boiler Repair	2001	3,340		20	167	167	362	19
20	Boiler	2001	851		20	43	43	92	20
21	Boiler Repair	2001	10,192		20	510	510	1,104	21
22	Power Wc Repair	2001	575		20	29	29	63	22
23	Tiles	2001	1,550		20	78	78	233	23
24	Boiler Repair	2001	1,676		20	84	84	203	24
25	Motor	2002	582		20	58	58	107	25
26	Water Treatment	2002	1,692		20	141	141	259	26
27	Cable Lines	2002	518		20	52	52	86	27
28	Cable Lines	2002	1,025		20	103	103	171	28
29	Chiller	2002	890		20	89	89	148	29
30	Dining Room Renov	2002	17,195		20	1,720	1,720	2,579	30
31	Leasehold Imrprovement	2002	689		20	69	69	86	31
32	Leasehold Improvements	2002	954		20	95	95	111	32
33	Leasehold Improvements	2002	1,910		20	191	191	223	33
34	TOTAL (lines 1 thru 33)		$ 11,966,423	$ 306,926		$ 347,109	$ 40,183	$ 1,863,680	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number South Shore Nsg & Rehab Ctr # 0042119 Report Period Beginning: 01/01/03 Ending: 12/31/03

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		$ 11,966,423	$ 306,926		$ 347,109	$ 40,183	$ 1,863,680	1
2	Pump Motor	2002	1,100		20	110	110	119	2
3	Water Treatment System	2002	1,004		20	100	100	142	3
4	Window Treatments	2002	650		20	65	65	103	4
5	Locks	2002	508		20	51	51	102	5
6	Chiller	2002	8,760		20	876	876	1,095	6
7	Carpeting	2003	527		20	75	75	75	7
8	Lighting And Ballists	2003	548		20	27	27	27	8
9	Covers	2003	750		20	69	69	69	9
10	Applied Sealcoating	2003	1,145		20	57	57	57	10
11	Carpeting For 14 Rooms	2003	24,080		20	1,433	1,433	1,433	11
12	Generator Service	2003	1,150		20	14	14	14	12
13	Door Keypads	2003	1,288		20	16	16	16	13
14	Front And Back Door Keypads	2003	958		20	12	12	12	14
15	Corner Guards	2003	1,788		20	30	30	30	15
16	Elevator Repair	2003	1,300		20	11	11	11	16
17	Paint	2003	1,652		20	28	28	28	17
18	Pave Lot	2003	1,376		20	23	23	23	18
19	Elevator Repair	2003	813		20	7	7	7	19
20	Wrist Band Trnsm.	2003	1,010		20	34	34	34	20
21	Sprinkler System	2003	581		20	15	15	15	21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 12,017,411	$ 306,926		$ 350,162	$ 43,236	$ 1,867,092	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number South Shore Nsg & Rehab Ctr # 0042119 Report Period Beginning: 01/01/03 Ending: 12/31/03

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		$ 12,017,411	$ 306,926		$ 350,162	$ 43,236	$ 1,867,092	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
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23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 12,017,411	$ 306,926		$ 350,162	$ 43,236	$ 1,867,092	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number South Shore Nsg & Rehab Ctr # 0042119 Report Period Beginning: 01/01/03 Ending: 12/31/03

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12D, Carried Forward		$ 12,017,411	$ 306,926		$ 350,162	$ 43,236	$ 1,867,092	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
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23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 12,017,411	$ 306,926		$ 350,162	$ 43,236	$ 1,867,092	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number South Shore Nsg & Rehab Ctr # 0042119 Report Period Beginning: 01/01/03 Ending: 12/31/03

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12E, Carried Forward		$ 12,017,411	$ 306,926		$ 350,162	$ 43,236	$ 1,867,092	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
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19									19
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21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 12,017,411	$ 306,926		$ 350,162	$ 43,236	$ 1,867,092	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number South Shore Nsg & Rehab Ctr # 0042119 Report Period Beginning: 01/01/03 Ending: 12/31/03

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12F, Carried Forward		$ 12,017,411	$ 306,926		$ 350,162	$ 43,236	$ 1,867,092	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
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23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 12,017,411	$ 306,926		$ 350,162	$ 43,236	$ 1,867,092	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number South Shore Nsg & Rehab Ctr # 0042119 Report Period Beginning: 01/01/03 Ending: 12/31/03

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12G, Carried Forward		$ 12,017,411	$ 306,926		$ 350,162	$ 43,236	$ 1,867,092	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
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19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 12,017,411	$ 306,926		$ 350,162	$ 43,236	$ 1,867,092	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number South Shore Nsg & Rehab Ctr # 0042119 Report Period Beginning: 01/01/03 Ending: 12/31/03

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12H, Carried Forward		$ 12,017,411	$ 306,926		$ 350,162	$ 43,236	$ 1,867,092	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
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19									19
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24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 12,017,411	$ 306,926		$ 350,162	$ 43,236	$ 1,867,092	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number South Shore Nsg & Rehab Ctr # 0042119 Report Period Beginning: 01/01/03 Ending: 12/31/03

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12I, Carried Forward		$ 12,017,411	$ 306,926		$ 350,162	$ 43,236	$ 1,867,092	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
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24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 12,017,411	$ 306,926		$ 350,162	$ 43,236	$ 1,867,092	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number South Shore Nsg & Rehab Ctr # 0042119 Report Period Beginning: 01/01/03 Ending: 12/31/03

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12J, Carried Forward		$ 12,017,411	$ 306,926		$ 350,162	$ 43,236	$ 1,867,092	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
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25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 12,017,411	$ 306,926		$ 350,162	$ 43,236	$ 1,867,092	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number South Shore Nsg & Rehab Ctr # 0042119 Report Period Beginning: 01/01/03 Ending: 12/31/03

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	240		1998	1998	$ 11,715,725	$ 260,958		$ 334,735	$ 73,777	$ 1,830,388	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Fence - South Shore Building Company			1998	10,094	-		505	505	2,525	9
10											10
11											11
12											12
13											13
14											14
15											15
16											16
17											17
18											18
19											19
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21											21
22											22
23											23
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25											25
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27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A-BLDG, Line 70 for total

Facility Name & ID Number South Shore Nsg & Rehab Ctr # 0042119 Report Period Beginning: 01/01/03 Ending: 12/31/03

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			$	$		$	$	$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
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54									54
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56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 11,725,819	$ 260,958		$ 335,240	$ 74,282	$ 1,832,913	70

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number South Shore Nsg & Rehab Ctr # 0042119 Report Period Beginning: 01/01/03 Ending: 12/31/03

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	2201 Main, LLC		2002		$ 30,970	$ 774		$ 774	$	$ 839	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	2201 Main, LLC			2002	28,676	1,434		1,434		1,553	9
10	2201 Main, LLC			2003	25,363	634		634		634	10
11											11
12											12
13											13
14											14
15											15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A-REP, Line 70 for total

Facility Name & ID Number South Shore Nsg & Rehab Ctr # 0042119 Report Period Beginning: 01/01/03 Ending: 12/31/03

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			$	$		$	$	$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 85,009	$ 2,842		$ 2,842	$	$ 3,026	70

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number South Shore Nsg & Rehab Ctr # 0042119 Report Period Beginning: 01/01/03 Ending: 12/31/03

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 1,100,840	$ 186,110	$ 116,402	$ (69,708)	10	$ 651,632	71
72	Current Year Purchases	55,297	2,556	7,551	4,995	10	7,551	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	$ 1,156,137	$ 188,666	$ 123,953	$ (64,713)		$ 659,183	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76		Alloc. Care Centers, Inc.		$ 32,204	$ 3,482	$ 3,482	$	5	$ 25,342	76
77										77
78										78
79										79
80	TOTALS			$ 32,204	$ 3,482	$ 3,482	$		$ 25,342	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 13,580,226	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 499,074	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 477,596	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ (21,478)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 2,551,616	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Facility Name & ID Number South Shore Nsg & Rehab Ctr # 0042119 Report Period Beginning: 01/01/03 Ending: 12/31/03

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5	Alloc. - CCI				5,025			5
6								6
7	TOTAL				$ 5,025 **			7

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized
by the length of the lease .

9. Option to Buy: ☐ YES ☐ NO Terms: *

10. Effective dates of current rental agreement:
Beginning
Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2004	$
13.	/2005	$
14.	/2006	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☐ NO

16. Rental Amount for movable equipment: $ 12,138 Description: See Attached Schedule
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	Facility	GM Vehicle	$ 328.73	$ 657	17
18					18
19					19
20					20
21	TOTAL		$ 328.73	$ 657	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number South Shore Nsg & Rehab Ctr # 0042119 Report Period Beginning: 01/01/03 Ending: 12/31/03

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD?
   - [ ] YES
   - [X] NO

   If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER AIDE ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER AIDE ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

SEE ACCOUNTANTS' COMPILATION REPORT

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	39 - 03	hrs	$		$ 316,231	$		$ 316,231	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs			11,855			11,855	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39 - 03	hrs			292,722			292,722	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39 - 02	# of prescrpts				246,232		246,232	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify): See Supplemental			19,313			180,219		199,532	13
14	TOTAL			$ 19,313		$ 620,808	$ 426,451		$ 1,066,572	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number South Shore Nsg & Rehab Ctr # 0042119 Report Period Beginning: 01/01/03 Ending: 12/31/03

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/03 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 8,557	$ 24,140	1
2	Cash-Patient Deposits	97,117	97,117	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	1,531,713	1,531,713	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments	5,811,466	5,811,466	5
6	Prepaid Insurance	275,950	275,950	6
7	Other Prepaid Expenses	1,190	1,190	7
8	Accounts Receivable (owners or related parties)	1,068,456		8
9	Other(specify): See Attached Schedule	134,309	134,309	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 8,928,758	$ 7,875,885	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		352,000	13
14	Buildings, at Historical Cost		10,177,369	14
15	Leasehold Improvements, at Historical Cost	183,869	646,488	15
16	Equipment, at Historical Cost	216,529	2,665,221	16
17	Accumulated Depreciation (book methods)	(184,846)	(4,276,409)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): See Attached Schedule		55,898	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 215,552	$ 9,620,567	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 9,144,310	$ 17,496,452	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 1,164,858	$ 1,164,858	26
27	Officer's Accounts Payable		284,480	27
28	Accounts Payable-Patient Deposits	92,208	92,208	28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	303,345	303,345	30
31	Accrued Taxes Payable (excluding real estate taxes)	15,854	15,854	31
32	Accrued Real Estate Taxes(Sch.IX-B)	350,813	350,813	32
33	Accrued Interest Payable		65,464	33
34	Deferred Compensation			34
35	Federal and State Income Taxes	4,583	4,583	35
	Other Current Liabilities(specify):			
36	See Attached Schedule	78,692	78,692	36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 2,010,353	$ 2,360,297	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		12,776,250	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	See Attached Schedule			43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$	$ 12,776,250	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 2,010,353	$ 15,136,547	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 7,133,957	$ 2,359,905	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 9,144,310	$ 17,496,452	48

SEE ACCOUNTANTS' COMPILATION REPORT

***(See instructions.)**

Facility Name & ID Number South Shore Nsg & Rehab Ctr # 0042119 Report Period Beginning: 01/01/03 Ending: 12/31/03

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 5,327,676	1
2	Restatements (describe):		2
3	**Bad Debt Expense**	175,000	3
4	**Rounding Adjustment**	3	4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 5,502,679	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	1,811,278	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	(180,000)	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 1,631,278	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 7,133,957	24 *

*** This must agree with page 17, line 47.**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number South Shore Nsg & Rehab Ctr # 0042119 Report Period Beginning: 01/01/03 Ending: 12/31/03

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 11,240,309	1
2	Discounts and Allowances for all Levels	(3,200,618)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 8,039,691	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	2,971,139	6
7	Oxygen	14,773	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 2,985,912	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	250,896	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	41,952	19
20	Radiology and X-Ray	10,670	20
21	Other Medical Services	210,745	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 514,263	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	289,428	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 289,428	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See Supplemental Schedule	86	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 86	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 11,829,380	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,675,350	31
32	Health Care	3,188,657	32
33	General Administration	2,193,333	33
	B. Capital Expense		
34	Ownership	1,762,775	34
	C. Ancillary Expense		
35	Special Cost Centers	1,066,587	35
36	Provider Participation Fee	131,400	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 10,018,102	40
41	**Income before Income Taxes (line 30 minus line 40)****	1,811,278	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 1,811,278	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? Not Complete If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.** SEE ACCOUNTANTS' COMPILATION REPORT

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.

Facility Name & ID Number South Shore Nsg & Rehab Ctr # 0042119 Report Period Beginning: 01/01/03 Ending: 12/31/03

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,398	1,501	$ 50,895	$ 33.91	1
2	Assistant Director of Nursing	4,949	4,931	90,161	18.28	2
3	Registered Nurses	9,240	10,170	225,686	22.19	3
4	Licensed Practical Nurses	55,646	60,265	1,132,555	18.79	4
5	Nurse Aides & Orderlies	122,921	129,840	1,117,234	8.60	5
6	Nurse Aide Trainees					6
7	Licensed Therapist	222	221	19,313	87.39	7
8	Rehab/Therapy Aides	7,970	8,630	97,690	11.32	8
9	Activity Director	2,095	3,126	33,182	10.61	9
10	Activity Assistants	14,646	15,730	120,726	7.67	10
11	Social Service Workers	11,744	12,890	133,343	10.34	11
12	Dietician					12
13	Food Service Supervisor	4,383	4,814	64,489	13.40	13
14	Head Cook					14
15	Cook Helpers/Assistants	29,837	31,713	243,874	7.69	15
16	Dishwashers					16
17	Maintenance Workers	3,530	3,732	45,414	12.17	17
18	Housekeepers	31,148	33,151	237,436	7.16	18
19	Laundry	13,742	14,746	109,209	7.41	19
20	Administrator	1,461	1,550	36,954	23.84	20
21	Assistant Administrator	2,493	2,694	51,062	18.95	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	9,940	10,804	76,583	7.09	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	2,156	2,357	22,629	9.60	31
32	Other Health Care(specify)					32
33	Other(specify) See Supplemental	2,906	3,256	26,831	8.24	33
34	TOTAL (lines 1 - 33)	332,427	356,121	$ 3,935,266 *	$ 11.05	34

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	506	$ 11,725	01-03	35
36	Medical Director	Monthly	9,000	09-03	36
37	Medical Records Consultant	Monthly	4,128	10-03	37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	2,095	10-03	39
40	Physical Therapy Consultant	29	1,580	10a-03	40
41	Occupational Therapy Consultant	54	1,526	10a-03	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	24	1,152	11-03	44
45	Social Service Consultant	12	577	12-03	45
46	Other(specify)				46
47					47
48	Care Center Salary		40,960	Various	48
49	TOTAL (lines 35 - 48)	625	$ 72,743		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses	131	$ 7,834	10-03	50
51	Licensed Practical Nurses				51
52	Nurse Aides				52
53	TOTAL (lines 50 - 52)	131	$ 7,834		53

SEE ACCOUNTANTS' COMPILATION REPORT

* This total must agree with page 4, column 1, line 45.

** See instructions.

Facility Name & ID Number South Shore Nsg & Rehab Ctr # 0042119 Report Period Beginning: 01/01/03 Ending: 12/31/03

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Elizabeth Williams	Administrator	0.00%	$ 36,954
David Vardi	Asst. Administrator	0.00%	51,062
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 88,016

B. Administrative - Other

Description	Amount
Management Fees - Eric Rothner	$ 180,000
Management Fees - Sandy Bokor	12,000
Management Fees - Alan Abrams	12,000
See Supplemetal Schedule	12,000
TOTAL (agree to Schedule V, line 17, col. 3)	$ 216,000
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
Care Centers, Inc.	Accounting	$ 33,000
Care Centers, Inc.	Legal	21,900
See Attached Schedule	Legal	5,297
Care Centers, Inc.	Bookkeeping Service	48,960
ADP	Data Processing	7,177
Alpha Data	Data Processing	565
Care Centers, Inc.	Data Processing	8,643
Care Centers, Inc.	Home Office Expense	201,600
Care Centers, Inc.	Ancillary Admin. Services	28,800
BDO Seidman	Line of Credit Audit Fee	478
Care Centers, Inc.	Compliance Phone Svc.	53
See Supplemetal Schedule		47,729
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 404,202

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 110,957
Unemployment Compensation Insurance	55,889
FICA Taxes	296,936
Employee Health Insurance	143,393
Employee Meals	7,950
Illinois Municipal Retirement Fund (IMRF)*	
Other Employee Benefits	9,683
Chicago Employer Tax	13,805
Penison	12,270
TOTAL (agree to Schedule V, line 22, col.8)	$ 650,883

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	3,978
Health Care Worker Background Check	
(Indicate # of checks performed)	
License & Fees	10,465
Advertising & Promotion	4,922
Dues and Subscriptions	8,289
Employee Recruitment	15,600
Allocated - Care Centers, Inc.	1,566
See Supplemental Schedule	12
Less: Public Relations Expense	( )
Non-allowable advertising	(4,922)
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 39,910

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	477
Allocated - Care Centers, Inc.	983
See Supplemental Schedule	358
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 1,818

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number South Shore Nsg & Rehab Ctr # 0042119 Report Period Beginning: 01/01/03 Ending: 12/31/03

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006	FY2007	FY2008
1	N/A		$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number South Shore Nsg & Rehab Ctr # 0042119 **Report Period Beginning:** 01/01/03 **Ending:** 12/31/03

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **No**

(2) Are there any dues to nursing home associations included on the cost report? **Yes**
If YES, give association name and amount. **IL Council on Long Term Care $8,289**

(3) Did the nursing home make political contributions or payments to a political action organization? **Yes** If YES, have these costs been properly adjusted out of the cost report? **Yes**

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **No** If YES, what is the capacity? **N/A**

(5) Have you properly capitalized all major repairs and equipment purchases? **Yes**
What was the average life used for new equipment added during this period? **10 Years**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **3,447** Line **10-2**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **Yes** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **No**
If YES, give effective date of lease. **N/A**

(9) Are you presently operating under a sublease agreement? YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.
N/A

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. $ **131,400**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **No** If YES, attach an explanation of the allocation.

SEE ACCOUNTANTS' COMPILATION REPORT

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **Yes**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **No** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **7,950** Has any meal income been offset against related costs? **No** Indicate the amount. $ **N/A**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **No**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **No** If YES, please indicate the amount of income earned from such a program during this reporting period. $ **N/A**
c. What percent of all travel expense relates to transportation of nurses and patients? **None**
d. Have vehicle usage logs been maintained? **N/A**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **N/A**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report?
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. $ **N/A**

(17) Has an audit been performed by an independent certified public accounting firm? **No**
Firm Name: **N/A** The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? **N/A** If no, please explain. **N/A**

(18) Have all costs which do not relate to the provision of long term care been adjusted out out of Schedule V? **Yes**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? **Yes**
Attach invoices and a summary of services for all architect and appraisal fees.